

Ageless Aesthetics MD, LLC

GENERAL CONSENT FOR AESTHETIC & WELLNESS SERVICES

I voluntarily consent to evaluation, consultation, and aesthetic and/or wellness treatments provided by Florida Surgical Clinic / Ageless Aesthetics / Dr. Denise Baker, including services performed by physicians and other licensed or supervised medical personnel acting within their scope of practice under Florida law.

I understand these services are **elective** and intended to improve appearance, wellness, or quality of life. No guarantees or assurances regarding results have been made.

Services Covered

Services may include but are not limited to aesthetic and medical consultations; injectable treatments (e.g., neuromodulators, dermal fillers, PRP/PRF); laser, light-based, radiofrequency, or energy-based treatments; IV hydration and wellness infusions; chemical peels; skin resurfacing; medical-grade skincare; and combination or maintenance therapies. Additional procedure-specific consent forms may be required.

Risks & Complications

I understand all procedures carry risks, including but not limited to pain, bruising, swelling, redness, bleeding, infection, scarring, pigmentation changes, asymmetry, unsatisfactory results, burns or thermal injury, allergic reactions, vascular complications, headache, dizziness, nausea, fainting, and IV-related complications. Some side effects may be temporary or permanent.

Medical History & Patient Responsibilities

I confirm that I have provided complete and accurate medical history, including conditions, medications, supplements, allergies, pregnancy/breastfeeding status, and prior aesthetic treatments. I understand that withholding information may increase risks and release the Practice from liability related to undisclosed conditions.

Alternatives & Right to Refuse

I have had the opportunity to ask questions, understand treatment alternatives (including no treatment), and may decline or discontinue treatment at any time without affecting future care.

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No Guarantee of Results

I understand results vary between individuals, are subjective, and no guarantees or warranties have been made regarding outcomes or longevity.

Photography

I consent to clinical photography for medical documentation, treatment planning, and progress comparison.

IV Therapy (If Applicable)

I understand IV therapy is not intended to diagnose, treat, cure, or prevent disease; benefits are not guaranteed; and I may stop treatment at any time. IV services are provided under licensed medical supervision.

Financial Responsibility

I understand that aesthetic and wellness services are generally not covered by insurance and agree to be financially responsible for all services rendered, including packages, maintenance treatments, and applicable fees.

Release of Liability

To the fullest extent permitted by Florida law, I release and hold harmless the Practice and its providers from liability for known and unknown risks associated with treatment, except in cases of gross negligence or willful misconduct.

Acknowledgment & Consent

I certify that I have read and understand this consent, all questions have been answered, and I voluntarily consent to treatment.

Patient Signature: _____ **Date:** _____

Printed Name: _____

Provider/Witness Signature: _____ **Date:** _____

Printed Name & Title: _____